Request for Amendment of PHI Form

To request an amendment of your medical information that Foundation Medicine, Inc. maintains, please complete this form.

PATIENT INFORMATION Please complete the following information:

Last Name[1] **First Name**[1] **Date of Birth**[1] **Phone**[2]

Postal Address[2] **Email Address**[2]

Ordered Test Number(s) (if known) **Test report date(s) (if known)** **Ordering Physician**

Signature of Patient or Personal Representative[1] **Date of Request**[1]

☐ Check box if you are signing as the personal representative of the patient and complete this section, including attaching the relevant requested documentation.

Personal Representative First and Last Name

Relationship of Personal Representative to Patient

Phone and/or Email Address of Personal Representative

Description of Personal Representative Authority
(please attach a copy of any relevant supporting documentation, such as a health care power of attorney or guardianship papers)

INFORMATION ABOUT YOUR REQUEST

Please describe what information you believe is inaccurate or incomplete and what change you are requesting.

PLEASE SEND THIS COMPLETED FORM

By email to: **privacy@foundationmedicine.com** By fax to: **617.418.2290** Or by mail to: **Foundation Medicine, Inc.**
Attn: Privacy Officer
150 Second St, Cambridge, MA 02141

1. Required information.
2. You must provide at least one of these fields so that we can contact you.

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